



IN THE UNITED STATES PATENT AND TRADEMARK OFFICE

Applicant: Gress
Serial No: 09/693,145
For: METHOD AND APPARATUS FOR CARD GAME
Filed: October 20, 2000
Examiner: A. Hunter
Art Unit: 3711
Customer No: 27623 Attorney Docket No.: 0001398USU

**AFFIDAVIT IN SUPPORT OF PETITION TO REVIVE ABANDONED
APPLICATION UNDER 37 CFR § 1.137(b)**

Edmund ("Bunky") A. Gress declares and says that:

1. I am the inventor of the above-referenced application, referred to herein as the present application.
2. I am President of Bunky's Enterprises, Inc.
3. Attachment 1 is a true and accurate copy of a letter dated April 16, 2000, documenting the general idea for the present application.
4. A provisional application was filed on June 1, 2000, which serves as the basis for the present application.
5. On July 19, 2000, I sustained a serious head injury upon falling off the edge of a stairwell while working for UPS.

RECEIVED

AUG 25 2003

OFFICE OF PETITIONS

This head injury included injury to my brain that affected my ability to comprehend statements made to me.

6. Attachment 2 is a true and accurate copy of Neuropsychological Examination Report completed by Robert P. Tepley, PhD.
7. Attachment 2 indicates the degree of the brain injury suffered.
8. The present application was filed based on the invention generally conceived prior to the brain injury.
9. I am currently on partial disability from work at UPS and have yet to return to work at UPS due to my injury.
10. From the time of the head injury to a few weeks ago, I did not have a full appreciation for the events that were unfolding around me. Particularly, I had difficulty comprehending the events surrounding the present application.
11. More particularly, I had great difficulty explaining the present application.
12. In fact, by the time of the Summer of 2001, my ability to comprehend had degraded significantly such that I was incapable of understanding the consequences of failing to respond to an Office Action.
13. I do not know if at the time of the due date for response to the last Office Action (dated June 27, 2001) in the

present application, whether I was given notice of the fact that the application was abandoned.

14. I also do not know, since I did not then have an ability to recall due to my brain injury, if I was ever advised by my prior counsel of the ramifications of not responding to the Action.
15. Until my recent meeting with present counsel, I did not comprehend the consequences of abandonment for failure to respond to an Office Action meant.
16. I have only recently, namely the past several weeks, been able to understand and appreciate the events surrounding the present application, including the result of having failed to timely respond to the Action and, thus, the resulting abandonment of the present application.
17. The complete delay from the Action until present was unintentional as I was incapable due to my brain injury, of comprehending the ramifications of the failure to respond. In fact, present counsel has had to slowly and repetitively go over the effect so that I now comprehend the result.
18. I am filing the Petition since I can not guarantee since I filed the original application whether I disclosed the invention or application to anyone else.
19. I do not know of any product on the market that would be effected should my application issue.
20. Based on these unique facts, I ask for re-instatement of my

application.

Date 8/14/03

E. Gress

Name: Edmund A. Gress

STATE OF Connecticut)
COUNTY OF Saunder) SS

Sworn to before me this 14th day of August, 2003.



Joanne A. Romaniello
Notary

JOANNE A. ROMANIELLO
NOTARY PUBLIC
My Commission Expires August 31, 2005

ATTACHMENT 1

April 16, 2000
Edmund Arthur Gress
1 Linden St. Unit C-6
Norwalk, CT. 06851
(203)845-0259

Dear Edmund Arthur Gress,

I am writing this letter, to myself, to begin the documentation of an idea I have had for about a year. The idea I have pertains to the 'Wrestling Industry'. This idea can be utilized by all professional communities. The idea is to create two separate deck of cards. One deck to be designated the "Wrestling Match Series", and the other the "Wrestler's Comparison Series".

The "Wrestling Match Series" would be a deck of cards where each card would have the name of a certain wrestler, his/her statistics, (such as weight, height, bicep/tricep size, quickness, win/loss ratio, and charisma - or others), his/her 'best move' of attack, the amount of damage he/she would inflict on his opponent, how much a wrestler can reguvinate between rounds, and how much damage he/she can endure from his/her opponent. Perhaps there could be varations on the amount of damage depending on other factors, such as the opponent's strength, or weight, or quickness. The player with the most charisma could go first. And the the play would continue according to the cards. Play would continue until, by both wrestler's, until one of the wrestlers has used up all of his 'hit points', or endurance. The wrestler still standing would win the card if that has been agreed by both players. Or you count it as one victory. The player with the most victories would win the game. Or after all matches were finished the player with the most matches would win all the card's. It could be called "Vince McMann" style.

The "Wrestler's Comparison Series" would simply have a wrestler's name, and certain statistics about himself/herself (such as: weight, height, bicep/tricep size, win/loss ratio, quckness, and/or others) that would be compared to an opponent's statistic's on the opponent's card. the player with the best statistic would win the opponent's card if that has been agreed by both players. The players would agree on which player would start first. Then that player would call out a statistical catagory, such as weght. He/she would then state his wrestler's weght. His/her opponent would then state his wrestlers' weght. The player who's wrestler had the greatest amount of weight would either win a point, or you could call it a match. The game could be played were the winner wins the other card, or by point - matches, or no cards are exchanged until all matches had been played. The matches would be counted up, and the one with the most matches would win all the cards from all matches played by the opponents - "Vince McMann" style.

Signed,

Edmund Arthur Gress
Edmund Arthur Gress

4-16-00

ATTACHMENT 2



Neuropsychological
Associates
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Robert A. Novelly, Ph.D., Dir.

Robert P. Tepley, Ph.D.

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December 17, 2001

Halina Snowball, MD
6 Greenwich Office Park
Greenwich, CT 06831

Patient: Gress, Edmund

Date of Birth: 09/03/1962

Date of Accident: 07/19/2000

Dates of Exam: 08/07/01, 08/17/01, 08/23/01, 08/30/01, 10/11/01, & 10/17/01

Dear Dr. Snowball:

This 39 year-old right-hand dominant, Caucasian single male was seen in neuropsychological examination, per your referral, to ascertain the nature and extent of cognitive and affective impairment, if any, secondary to an approximately six foot fall onto the right side of his head and body. No loss of consciousness occurred and there is no reported evidence of an impaired level of consciousness (e.g., confusion, speech disturbance, etc...). He recalls people asking him if he was okay and being in pain. The patient says he then called his boss, who brought him to a UPS physician. At the time of the accident he was delivering a package as an employee of UPS.

He currently describes a wide range of physical, cognitive, affective, and behavioral symptoms, many of which have appeared in the weeks prior to his coming for this evaluation. Notably, he reports "violent behavior and urges", for example, the feeling of wanting to drive his automobile into ongoing traffic. He also says he has banged his TV remote against his head in frustration.

Additional reported problems include right-left confusion, pain in his head, a period of "no emotion" for some time after the accident, followed by increased agitation and recurrence of his sleep problems recently, which were problematic immediately following the accident. He says his "thinking is 01/1000th of what it was before the accident". It sounds as though he had a very active, somewhat disorganized inner life prior to the accident, which has now quieted substantially.

Since the accident, he has not resumed working with UPS. However, he tells me he has started a food delivery business, which is going quite well.

Background/History

Medical history is non-contributory. He denies ever consulting a neurologist, psychologist or psychiatrist for any reason prior to the accident. He denies history of hypertension, high cholesterol, seizures, concussion, asthma, headaches, or seizures. He believes his parents have described him as delayed in his walking and talking as a child, but he does not know the details.

Academically, he completed high school at New Canaan High School with mainly grades of A's and B's during his first two years with significant decline in his grades during the latter two years. He attended three different colleges/universities and eventually graduated with a 2.88 GPA. Academic performance reportedly varied with effort.

He has worked for UPS for six years. Prior to that he worked delivering pizza (6 months), delivering chicken (7 months), and before that lived in Oregon working as a bartender and waiter. The patient reports that he traveled throughout 48 states, by himself, during this time.

There is a history of marijuana use for about a decade with reportedly complete abstinence during the past 10 years. He also has not used alcohol at all for the past 12 years, stating that he never was a heavy drinker. He says he has not used any recreational drugs in over a decade.

Records Reviewed

The following records were provided by the patient's attorney and reviewed in detail:

Dr. Herbert I. Hermele, Orthopaedic Specialty (evaluation of 10/25/00)

Dr. Joel Feigenson, Neurology (evaluation of 12/29/00)

Dr. Halina Snowball, Physiatry (evaluations of 09/12/00 & 07/10/01, plus various notes)

Dr. Steven Baskin, Psychology (illegible writing, 09/27/00)

Dr. Livia Caldeira, Psychology (06/11/01)

Summarizing these various records, the patient has been cleared for work from an orthopedic standpoint. His neurological exam has been consistently normal and he has variously complained of cognitive, affective and behavioral symptoms as well as significant back pain. He has been diagnosed with myofascial pain syndrome and mild traumatic brain injury. He had a head CT, which I understand was negative for intracranial bleeding, fracture, or other structural damage. A CT scan of the cervical spine apparently showed a central bulge at the C5-6 level, which was judged to have unclear relevance to the accident of 07/19/00. Also noted is a reference to questionable Lyme Disease and treatment with Doxycycline in October 2000.

Examination Results

Mental status examination reveals an alert, fully oriented individual with coherent, logical, goal-directed thought processes. Affect is broad and appropriate; mood is euthymic appearing. He frequently provides "updates" about various physical symptoms and especially his cognitive and affective status. On two occasions, he complained that his frustration and anger level were such that he needed to discontinue the examination for that day. He never displays any signs of behavioral dyscontrol. The patient denies auditory or visual hallucinations and these symptoms

are not observed. He complains of bouts of significant depression since the accident but currently is more concerned with his level of anger.

The patient was examined with a battery of standardized, quantitative procedures. Results are presented in percentile ranks when appropriate. The 50th %-tile represents the mid-normative level for the patient's age. Additionally, capacities are referenced to expected levels based on estimated pre-morbid intellectual functions. No decline in general intellect is evidenced by this patient. Hence, Wechsler IQ indices provide the standard to which other areas of cognitive function are compared.

Wechsler IQ indices are as follows:

Verbal IQ	=	114	(82 nd %-tile)
Performance IQ	=	117	(87 th %-tile)
Full Scale IQ	=	116	(86 th %-tile)

The above results are consistent with high average pre-morbid intellectual capacities. Therefore, areas of cognitive functioning falling below approximately the 37th %-tile raise the possibility of acquired deficits in higher cortical functions.

Motor/Dexterity. Examination of upper extremity motor functions demonstrates unimpaired capacity with the non-dominant left hand and inferior/impaired capacity with the dominant right hand. Specifically, rapid alternating movements (Luria) are mid-normative with the non-dominant hand (52nd %-tile) and mildly below expectations with the dominant right hand (24th %-tile). Fine motor dexterity (Lafayette) is again unimpaired with the left (44th %-tile), but severely deficient with the dominant right hand (2nd %-tile).

Construction. No construction dyspraxia, tremor or spatial neglect is demonstrated on a complex figure copy drawing procedure (Rey). There are elements of inadequate planning apparent. Further evaluation of spatial neglect, via a line bisection procedure, reveals no impairment.

Visual/Spatial. Foundation aspects of the visual perceptual system are intact and show no gross abnormalities. Visual integrative capacity is at the expected level (Hooper, 62nd %-tile). Additionally, visual perceptual problem solving (e.g., with shapes and designs) is consistently in the high average range, as measured by the Wechsler procedure (PIQ = 117, 87th %-tile).

Rapid horizontal scanning for recurring numbers or novel designs, respectively, is in the borderline impaired range (WJ-R Processing Speed, 36th %-tile).

Speech/Language. Speech is fluent, prosodic and grammatical. No aphasic, paraphasic, or word-retrieval difficulties are apparent during conversations. Confrontation naming of line drawings is within the expected range (Boston Naming, 55th %-tile). In contrast, a measure of verbal fluency, or capacity to rapidly generate words of a given phoneme, is mildly below expectations (FAS, 22nd %-tile).

Attention/Concentration. Capacity in this area is essentially unimpaired with a questionable degree of variability demonstrated. Repeating digits forward and backward is at the 37th %-tile.

However, performance on a unquestionably more demanding procedure (with regard to concentration or working memory) is within the expected range and at the 75th %-tile (Letter-Number Sequencing). Mental arithmetic is also within the expected range (63rd %-tile).

No behavioral manifestations of distractibility, impulsivity or inattention are observed throughout the examination.

Memory. The *Memory Assessment Scales* was administered to ascertain current levels of auditory/verbal memory and visual memory. The following indices are obtained:

Verbal Memory	=	92	(30 th %-tile)
Visual Memory	=	83	(13 th %-tile)
Global Memory	=	85	(16 th %-tile)

The above indices are clearly below expected capacities based on pre-morbid intellectual/cognitive abilities.

Performance on the verbal memory portion of the exam indicates significant problems with encoding, consolidation, and retrieval of verbal information. As is typical, a greater level of impairment is demonstrated when learning a list of random words (9th %-tile) versus a narrative story (50th %-tile). The narrative recall procedure incorporates a degree of structure and logic that facilitates learning and is less susceptible to most types of memory impairment, compared to the list learning procedure.

With regard to visual memory, the patient demonstrates significant deficits in both visual recognition recall (16th %-tile) and capacity to reproduce novel designs from memory (16th %-tile).

The patient was also administered the *Victoria Symptom Validity Test* to ascertain if non-cognitive factors may be contributing to this patient's memory impairment. The results indicate no evidence of any attempt to feign or exaggerate cognitive/memory deficiency.

Executive/Frontal. Various measures of executive functions were administered. As noted previously, verbal fluency is below expectations and at the 22nd %-tile. This procedure is susceptible to liabilities in functions mediated by the frontal lobes of the brain, especially the dominant hemisphere.

Rapid sequencing of numbers demonstrates mildly impaired capacity (Trails A, 36th %-tile). A similar degree of impairment is noted when the patient must rapidly sequence alternating numbers and letters (Trails B, 29th %-tile). These findings indicate mild difficulties with rapid conceptual tracking and mental flexibility.

Capacity to inhibit a habitual response in favor of an unusual response demonstrates severe impairment (Stroop Interference, 1st %-tile). This procedure requires the patient rapidly to identify the ink color (e.g., red, green, or blue) of non-corresponding color words (e.g., the word "Red" printed in blue ink).

Finally, performance on a non-verbal conceptual problem solving procedure is unimpaired and within the expected range (WCST, 6 categories). There is no evidence of perseveration or failure to maintain conceptual set demonstrated on this procedure.

Affect/Personality. Several objective measures of personality and affective functioning were administered, including the MMPI-2, Symptom Checklist-90-R, and the Patient Pain Profile. Results indicate a willingness to disclose affective and personality liabilities without any evidence to suggest exaggeration or minimization of symptoms. There is a tendency to focus on physical or somatic symptomology, but certainly not to a degree consistent with Somatization Disorder or Conversion Disorder.

In terms of pain complaints, the level of depression, anxiety and somatization endorsed by this patient more closely resembles that of a non-pain community sample rather than a chronic pain group. This suggests no clinically significant affective contribution to his pain complaints or any significant secondary affective reactions to pain at this point. The nature and severity of pain is unrelated to the cognitive deficits demonstrated, to any clinically meaningful degree.

Only mild levels of depressive symptomology and no significant levels of anxiety are apparent. The patient endorses feelings of anger and hostility, which he experiences as difficult to control. He also reports thought disorganization and difficulties with his thinking more generally. His history does not suggest long-standing difficulties with self-control or aggressive behaviors. The only legal history is a short imprisonment followed by probation for growing marijuana about 10 years ago. A certain degree of "unusualness" likely was present in his thought processes prior to the accident, but it is difficult to characterize the nature of his thinking in the past.

Notably, the MMPI-2 profile (3-1-8) is typical of patients with schizophrenic disorders or psychotic disorders. Clearly, this patient does not appear schizophrenic, despite any pre-morbid peculiarities in his thought processes. He also does not present with paranoia. This profile is also common among individuals with head injury or certain other neurological disorders. The MMPI-2 was not originally standardized with neurological patients and is unable reliably to differentiate neurologically impaired from psychiatrically disordered individuals, independent of significant other clinical data. Hence, the history, clinical presentation, and objective findings on the cognitive exam indicate with reasonable certainty that this patient is neuro-psychologically impaired rather than psychotic/schizophrenic. Of course, he also may be experiencing an exacerbation of pre-morbid "subclinical" affective and/or cognitive processing liabilities.

Summary Impression

This 39-year old right-hand dominant Caucasian male is approximately 13 months post-injury at the time of this exam. He was referred for neuropsychological examination to ascertain whether or not he has cognitive, behavioral, and/or affective liabilities consistent with mild closed head injury from an accident on 07/19/00, when he fell about six feet onto the right side of his head and body.

The examination demonstrates no decline in overall intellectual capacity, which is in the high average range. Clinically significant deficits are apparent in memory functioning, both verbal and visual aspects of memory, and certain executive/frontal lobe capacities. Finally, there is an

inferiority with regard to motor speed and dexterity with the dominant right hand compared to the left hand.

Apparently, no peripheral or spinal cord injury accounts for the right-sided motor impairments demonstrated [This conclusion is based primarily on the determination of others (e.g., Dr. Feigenson) that the cervical spine CT scan findings are not from the accident and asymptomatic with regard to the patient's physical symptoms].

Also, medication side effects do not appear to have any meaningful role in this patient's cognitive symptoms. He is not able to recall by name the medications he takes, but believes he recently resumed taking Pamelor for sleep. He has also been on at times nortriptyline and over-the-counter non-steroidal anti-inflammatories. He does not take anticonvulsants, opioid analgesics, or tranquilizers.

Pain also is not a clinically meaningful contributor to the cognitive deficits demonstrated.

The specific executive liabilities demonstrated, especially in the context of dominant hand inferiority in fine motor functions, reasonably suggests impairment in functions preferentially mediated by the left anterior area of the brain. The diagnosis of cognitive impairment in functions mediated by this brain region is independent from the ultimate etiology of the upper extremity, fine motor deficit. Of course, memory impairment is a common sequelae of mild head injury and may involve a number of possible brain regions. Memory deficits are often demonstrated in mild head injury patients even though there is no evidence of a structural lesion on brain CT or MRI.

The patient also complains of a variety of affective and behavioral changes since the accident, which are consistent with the sequelae of mild head injury. Overall, the evaluation indicates with reasonable certainty that he is neuro-psychologically impaired rather than psychotic or schizophrenic. However, he may be experiencing an exacerbation of pre-morbid affective and/or cognitive processing liabilities. In my judgment, compelling and convincing evidence of past history of psychosis or schizophrenic disorder would be necessary to warrant the alternative interpretation that his affective/personality symptoms are related exclusively to psychiatric factors. I find no such evidence, though this is based on the records reviewed and the patient's self-reported history.

His primary affective/personality complaints revolve around unwanted thoughts and feelings of anger/hostility as well as disorganization in thought processing more generally. I did not observe symptoms of behavioral dyscontrol or hostility, though on one occasion the patient did report having excessive levels of anger and frustration, at which point he requested that the session be discontinued. By his self-report, these symptoms subsided to a degree by later sessions.

There is no evidence of sociopathic personality or tendencies that might suggest he is malingering. Also, the exam does not indicate any evidence of dissimulation of cognitive deficits or affective liabilities, including on a procedure specifically designed to detect "non-cognitive" sources of memory problems (e.g., VSVT). He does provide somewhat over-elaborated explanations and descriptions of his symptoms. His report of symptoms appears somewhat inconsistent across evaluators, but the discrepancies are not extreme in my judgment and may be related to his perception of the evaluating physician's area of expertise/concern.

Despite the impairments and symptoms demonstrated, the functional implications for this patient do not appear to be substantial at this time. He has been able to start his own business with success (according to his own estimation, which is not objectively confirmed by me). Clearly, he is not partially or fully disabled from working from a cognitive standpoint. Nevertheless, he may demonstrate reduced efficiency at work because of his cognitive deficits and he may be less effective in the interpersonal aspects of his job because of his affective/personality liabilities. The quality and enjoyment of his life, socially and professionally, may also be diminished, though he is not currently with a Major Depression.

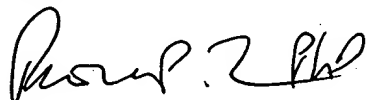
He is at increased risk for substance abuse and possible emotional deterioration in the future, given his history of substance abuse and now a mild head injury. It does not appear that he has resumed use of marijuana or other recreational drugs at this point.

Diagnosis

Concussion (no loss of consciousness) (850.0)
Postconcussion Syndrome (310.2)

Thank you for your kind referral of this patient. Please do not hesitate to call if you have any concerns or questions.

Sincerely,



Robert P. Tepley, PhD
Clinical Psychology & Neuropsychology

cc: Lawrence F. Morizio of Cousins, Johnson & Desrosiers, P.C.
Liberty Mutual (Insurance Company)



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Robert A. Novelly, Ph.D., *Dir.*

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January 4, 2002

Lawrence F. Morizio
2563 Main Street
Stratford, CT 06615

**Re: Gress, Edmund,
Addendum to Neuropsychological Examination of 12/17/01**

Date of Birth: 09/03/1962

Date of Accident: 07/19/2000

Dates of Exam: 08/07/01, 08/17/01, 08/23/01, 08/30/01, 10/11/01, & 10/17/01

Dear Mr. Morizio:

Per your request, the following is an addendum to my neuropsychological examination report (December 17, 2001) on the above patient. The purpose of the Addendum is to assign an impairment rating of the whole person based on the *AMA Guides to the Evaluation of Permanent Impairment*.

Addendum

As noted in the original report, I do not believe Mr. Gress has lost capacity for productive work or independent daily functioning. Nonetheless, he is likely to experience reduced efficiency and effectiveness in his work and also a lessened quality of life as a result of his cognitive, affective, and interpersonal difficulties. He is at risk for further affective deterioration, such as Major Depression, in the future and may require periodic psychotherapeutic intervention.

With reasonable clinical certainty it is my clinical opinion that Mr. Gress sustained a closed head injury as a result of the accident on 07/19/00. This conclusion is based on a thorough diagnostic interview, review of records, other relevant history, and results of standardized, quantitative evaluation of higher cortical functions (i.e., neuropsychological examination). He is more than 12 months post-injury, which is beyond the typical time frame for meaningful, significant recovery of cognitive functioning following closed head injury. He has permanent residual deficits in higher cortical functioning as well as mild disturbances in emotional regulation and social functioning under conditions of unusual stress.

The American Medical Association *Guides to the Evaluation of Permanent Impairment* include criteria for assigning percentage of impairment of the whole person resulting from injury to the brain. Mr. Gress has disturbances of complex, integrated cerebral functions as well as emotional disturbances resulting from brain damage. In my judgment and based on criteria delineated in the *AMA Guides*, the degree of impairment in complex, integrated cerebral functions is 10% and the degree of impairment in emotional functioning as a result of brain damage is 5%. Thus, the percent impairment of the whole person based on the *AMA Guides* is 10%.

These ratings indicate that the patient has objectively demonstrable deficits in higher cortical functioning but retains the capacity to carry out most activities of daily living as well as before the injury, and that he experiences a mild to moderate degree of emotional disturbance but only under conditions of unusual stress.

Please do not hesitate to contact me if you have any questions.

Sincerely,



Robert P. Tepley, PhD
Clinical Psychology & Neuropsychology

Cc: Halina Snowball, MD, 6 Greenwich Office Park, Greenwich, CT 06831
Liberty Mutual Insurance Company